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No. 01-1021

IN THE
Supreme Court of the United States

RUSH PRUDENTIAL HMO, INC.,
Petitioner,

v.

DEBRA C. MORAN AND STATE OF ILLINOIS,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE ILLINOIS STATE MEDICAL SOCIETY, AND THE AMERICAN PSYCHIATRIC ASSOCIATION, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") and the Illinois State Medical Society ("ISMS"), Illinois not-for-profit corporations, and the American Psychiatric Association ("APA") submit this brief *amicus curiae* in support of respondents Debra C. Moran and the State of Illinois.[1] Founded in 1847, the AMA is the largest medical society in the United States. Its approximately 275,000 physicians practice in all fields of medical specialization and in every state. The AMA is dedicated to promoting the science and art of medicine and the betterment of public health.

ISMS is an association of more than 11,000 physicians who reside or practice in the State of Illinois. It was founded in 1840 to promote the science and art of medicine, protect public health, elevate the standards of medical education, and unite the medical profession in Illinois.

The APA, with approximately 42,000 members, is the Nation's leading organization of physicians specializing in psychiatry. The APA has participated in numerous cases in this Court. The APA and its members have a strong interest in ensuring that HMO financial incentives do not impair patients' ability to receive proper medical care.

The members of the AMA, ISMS, and APA seek to protect the integrity of the patient-physician relationship in order to

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[1] Counsel for the AMA, the ISMS, and the APA authored this brief in its entirety. The AMA/State Medical Society Litigation Center ("Litigation Center") is a coalition of the AMA and private, voluntary, non-profit state medical societies established to present the views of the medical profession to the courts. The Litigation Center, representing the AMA and the 50 state medical societies which are its members, and the APA paid for this brief. No monetary contributions to the preparation or submission of this brief were received from any other source. Sup. Ct. R. 37.6. The parties have consented to the filing of this brief, and the consent letters have been filed with the Clerk of the Court. *Id.* 37.3.

provide quality medical care for patients. Their activities promote a health-care system in which all Americans have access to affordable medical care *and* in which treatment decisions are made by knowledgeable physicians who practice subject to traditional state regulation and the ethical values of the profession. In furtherance of these goals, the AMA has adopted the Principles of Medical Ethics, a set of "standards of conduct which define the essentials of honorable behavior for the physician." AMA, *Code of Medical Ethics* (2001), *available at* http://www.ama-assn.org/ama/upload/mm/ 369/2001_principles.pdf. Under these principles, physicians are obligated to "regard responsibility to the patient as paramount" and "to seek change to those [legal] requirements which are contrary to the best interests of the patient." *Id.* (Principles VIII, III). In addition, the AMA has sought to protect state jurisdiction over regulation of the quality of medical care and medical-necessity determinations from preemption by federal law. See AMA, H-165.875, *Establishment of Liability of Managed Care Organizations, in Policies of the AMA House of Delegates* ("*AMA Policy*") (1999), *available at* http://www.ama-assn.org/apps/pf_online (endorsing federal legislation to amend ERISA expressly to provide that state regulation of quality of medical care and medical-necessity determinations are not preempted).[2]

This case poses the question whether independent-review laws enacted by states are preempted by ERISA. Such laws require managed-care organizations to allow a neutral physician to review and resolve disputes between physicians, patients, and managed-care organizations about the medical

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[2] The health policies of the AMA are established by the House of Delegates. These policies "are based on professional principles and scientific standards" and "represent the consensus viewpoints of many thousands of physicians gained through years of professional practice." AMA, *PolicyFinder: About AMA Policy* (1995-1998), *available at* http://www.ama-assn.org/apps/pf_online.

necessity of treatment. These laws help ensure that patients enrolled in managed-care organizations receive medically-necessary health care. *Amici* have concluded, based on substantial academic research and commentary and significant practical experience, that independent-review laws, such as the statute upheld by the Seventh Circuit in this case, protect the integrity of the patient-physician relationship in the managed-care context and serve the best interest of patients. See AMA, H-285.931, *The Critical Role of Physicians in Health Plans and Integrated Delivery Systems, in AMA Policy* (adopting policy that patients' health plans and integrated health-care delivery systems should "be able to appeal the medical necessity determination or coverage decision to an independent review organization"); *id.* H-285.998, *Managed Care, in AMA Policy* ¶ 5 (same); *id.* H-320.952, *External Grievance Review Procedures, in AMA Policy* ¶ 3 (same); *id.* H-320.953, *Definitions of "Screening" and "Medical Necessity", in AMA Policy* ("[u]sage of the term 'medical necessity' must be consistent between the medical profession and the insurance industry").

The need for independent-review laws arises when the functions of insurer and health-care provider are merged, as they are in managed care. In these circumstances, a significant risk arises that medical-treatment decisions will be made, not by the patient's physician, but by a managed-care administrator who will subordinate proper patient care to cost considerations. As a practical matter, an HMO's decision to deny coverage for a prescribed medical treatment often results in the patient being unable to afford, and thus having to forgo, necessary treatment. Independent-review laws diminish such risks. They do so by regulating insurance and health care, two areas which lie at the heart of traditional state regulation and which presumptively are not preempted by federal law.

For these reasons, the AMA and other medical societies have promoted independent-review laws before state legislatures, the United States Congress, and courts

throughout the country. In addition, the AMA, as *amicus curiae* in the court below and in other cases addressing independent-review laws, has sought to defend such laws from assertions of preemption.

Here, the Seventh Circuit correctly held that the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001, *et seq.*) ("ERISA"), did not preempt Illinois' independent review law, 215 Ill. Comp. Stat. § 125/4-10(a) ("section 4-10(a)"). *Moran* v. *Rush Prudential HMO, Inc.*, 230 F.3d 959, 972 (7th Cir. 2000), *cert. granted*, 121 S. Ct. 2589 (2001). The Seventh Circuit concluded that section 4-10(a) permissibly regulates insurance and health care in the State of Illinois and does not impinge upon ERISA's remedial scheme. The *Moran* decision allows the state to protect insureds and patients and to preserve the patient-physician relationship by authorizing external, independent review in a non-judicial forum of disputes between insurers and a patient's primary care physician about proper medical treatment. In contrast, the Fifth Circuit has concluded that this traditional state regulation is preempted by ERISA, leaving a significant gap in the regulation of managed-care organizations and thus in the protection of insureds and patients. See *Corporate Health Ins., Inc.* v. *Texas Dep't of Ins.*, 215 F.3d 526, 538-39 (5th Cir. 2000). The resolution of this conflict is likely to determine the legal viability of all state independent-review laws.

Amici have a strong interest in the proper resolution of this case.

SUMMARY OF ARGUMENT

The issue in this case is whether Illinois and other states can enact laws requiring independent review of the medical-necessity determinations of HMOs acting as insurers or whether such laws are preempted by ERISA. The court of appeals in this case correctly concluded that Illinois' law

regulates insurance and health care and does not conflict with ERISA's civil enforcement scheme. The court therefore held that the law is not preempted by ERISA. *Amici* file this brief to demonstrate both that the decision below is correct and that state regulation of HMOs acting as insurers is consistent with ERISA's explicit preservation of state authority in this area and with its overall goal of protecting ERISA plan participants and beneficiaries.

An analysis of the preemption question at issue begins with the fundamental premise that Congress did not intend to preempt state regulation of insurance. Indeed, Congress included a savings clause that expressly preserves the states' authority to regulate insurers, even when that regulation "relates to" an ERISA plan. See 29 U.S.C. § 1144(b)(2). Equally critically, the court must presume that Congress did not intend to preempt Illinois' exercise of its power to regulate health care. See, *e.g.*, *Hillsborough County* v. *Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985).

Section 4-10(a) is a regulation of both insurance and health care and thus wholly saved from ERISA preemption, as is demonstrated by application of the framework found in *UNUM Life Insurance Co. of America* v. *Ward*, 526 U.S. 358, 367, 374 (1999). First, despite petitioner's and its *amici*'s protests to the contrary, section 4-10(a) applies only to HMOs acting as insurers, reinsurers, or agents for insurers performing an insurance function and thus regulates insurance from "'a common-sense view of the matter.'" *Id.* at 367 (quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 740 (1985)). Practically speaking, the independent-review law regulates only HMOs in a position to deny payment or coverage for a medical treatment that the insured patient's primary care physician deems medically necessary, *i.e.*, only HMOs acting as insurers. See *infra* 15-16. Moreover, whenever the HMO is providing or arranging for health care that spreads risk, it is legally obligated to provide the care and acting as a reinsurer. Indeed, an HMO that

arranges insured care and processes claims under such an arrangement is necessarily the agent of the insurer; it is performing the claims processing function, a core insurance function. Finally, the policy concerns underlying Section 4-10(a) are directed at HMOs acting as insurers.

This common sense perspective is confirmed by application of the McCarran-Ferguson guideposts. Section 4-10(a) serves as "an integral part of the policy relationship between the insurer and the insured," *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 743 (1985); "is limited to entities within the insurance industry," *UNUM Life*, 526 U.S. at 375; and spreads risk among policy holders, *id.* None of these factors is determinative but their application, aided by common sense, shows that section 4-10(a) is directed at the insurance business.

This Court's decision in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987) is the sole basis of the argument that independent-review laws are preempted, but there is no conflict between respondent's action filed under ERISA section 502(a) and ERISA's civil enforcement scheme. In *Pilot Life*, the ERISA plan beneficiary filed a state cause of action that was not saved from preemption by the insurance savings clause. In addition, he sought punitive damages for the denial of benefits from an ERISA plan although such damages are not permitted under ERISA's enforcement scheme. Here, respondent's claim is brought under section 502(a) of ERISA, invokes a law saved from preemption by the insurance savings clause as the rule of decision in her ERISA action, and seeks only the relief authorized by ERISA's civil enforcement scheme. *Pilot Life* should not be extended to these wholly different circumstances.

Section 502(a) of ERISA is the exclusive cause of action for ERISA benefits and was modeled on section 301(a) of the Labor Management Relations Act, the exclusive cause of action for enforcement of collective bargaining agreements. But independent-review laws, which define medical

necessity, are analogous to labor arbitration agreements, which define the meaning of collective bargaining agreements. No one contends or believes that the labor arbitration of the meaning of a collective agreement somehow impinges upon the exclusivity of section 301(a) in enforcing such agreements; similarly, the arbitration of medical-necessity decisions does not impinge upon the exclusivity of ERISA section 502(a).

Finally, the independent-review laws passed in Illinois and other states further ERISA's goal of complementary state and federal regulation protecting the rights of ERISA plan beneficiaries and participants. Exercising the police power to protect public health, the states have enacted independent-review laws to ensure that citizens whose health care is insured by HMOs receive medically-necessary treatment. The laws serve that important goal in critical ways. They require medical-necessity decisions to be made by physicians, protecting the health of the patient and the integrity of the patient-physician relationship. Independent review also gives patients an assurance that their interests are being fairly considered—even where the ultimate decision is that the insurer will not pay for the requested treatment. This, in turn, improves the public perception of the health-care system and may prevent substantial litigation. States are at the vanguard of the movement to protect patients through regulation like independent review; and, currently, their participation in the system is critical to ensuring that insured patients' health-care interests are guarded.

For all of these reasons, *amici* urge this Court to affirm the Seventh Circuit's decision, allowing states to continue their efforts to protect their citizens' health by regulating HMOs acting as insurers.

ARGUMENT

I. ERISA PRESERVES STATE REGULATION OF INSURANCE AND HEALTH CARE AND THUS STATE LAWS DIRECTED AT HMOS AS INSURERS.

Traditionally, health care in the United States was provided on a fee-for-service basis. Physicians and other health-care providers delivered care. They were separate from insurers, the entities responsible for paying for the treatment. In the late 1960s and early 1970s, increases in health-care costs led to the development of alternative forms of health-care delivery and financing, including HMOs and other managed-care organizations. These organizations assume some or all of the financial risk of providing health care. Put differently, in these organizations, in contrast to fee-for-service health care, the roles of health-care provider and insurer are merged. See generally *Pegram* v. *Herdrich*, 530 U.S. 211, 218-19 (2000).

This case, like other cases involving managed care, exists at the confluence of two powerful, traditional state interests – *viz.*, the state interests in the regulation of health care and of insurance. Section 4-10(a) of the Illinois Code requires HMOs to provide independent external review and determination of any dispute between an HMO and a patient's primary care physician "regarding the medical necessity of a covered service proposed by a primary care physician." 215 Ill. Comp. Stat. § 125/4-10(a). This law regulates health care and the insurance industry because the HMOs to which it applies are both health-care providers and insurers.[3]

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[3] *See* 42 U.S.C. § 300e(c) ("[e]ach HMO shall . . . assume full financial risk on a prospective basis for the provision of basic health services, except that a[n] [HMO] may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions"); 215 Ill. Comp. Stat. § 125/1-2(9) (defining an HMO as "any organization formed . . . to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers").

This Court has recently instructed that the scope of ERISA preemption must be determined against a background "assumption that the historic police powers of the States were not be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *New York Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 655 (1995); see also *DeBuono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 n.8 (1997). Pertinent here, there exists a strong presumption against ERISA preemption of state regulation of health care. "[N]othing in the language of [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Travelers*, 514 U.S. at 661 (citing *Hillsborough County*, 471 U.S. at 719). See also *Pegram*, 530 U.S. at 237; *DeBuono*, 520 U.S. at 815-16. And, ERISA itself expressly preserves state regulation of the business of insurance in section 514(b), 29 U.S.C. § 1144(b)(2). See also *UNUM Life*, 526 U.S. 373-75.

The nature of the regulation at issue thus militates strongly against a finding of ERISA preemption. That point is underlined by consideration of the implications of preemption in this context. ERISA does not substantively regulate HMOs' medical-treatment decisions. See, *e.g.*, *Travelers*, 514 U.S. at 651 (ERISA "does not go about protecting plan participants and their beneficiaries by requiring employers to provide any given set of minimum benefits"). Accordingly, to the extent state regulation is displaced, HMOs are not subject to any corresponding federal regulation. Ironically,

ERISA participants and beneficiaries – the object of Congressional solicitude in ERISA – will be deprived of protection.

Like the subject matter and the policy interests at stake here, a rigorous analysis of the statute and this Court's cases leads inexorably to the conclusion that section 4-10(a) is not preempted.

II. ILLINOIS' INDEPENDENT-REVIEW LAW IS DIRECTED TOWARD HMOS AS INSURERS AND DOES NOT CONFLICT WITH ERISA'S CIVIL ENFORCEMENT SCHEME.

Respondent Moran's action is a claim for benefits from an employee welfare plan under ERISA's civil enforcement provision, section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). Respondent contends that she is entitled to reimbursement for the cost of her microneurolysis surgery. Specifically, she asserts that under section 4-10(a), the Illinois statute providing for independent review of disputes between HMOs and primary care physicians, the independent reviewer determined that her surgery was medically necessary; that this determination was binding on the HMO; and that the independent-review process was not preempted by ERISA. The petitioner HMO asserts, however, that it determined that Moran was not entitled to this benefit and that section 4-10(a) is preempted.

Section 514(a) of ERISA preempts any state law to the extent that the law "relate[s] to any employee benefit plan." Although *amici* do not focus on this point, they agree with respondents that section 4-10(a) does not "relate[] to" an ERISA plan, as this Court has most recently developed that test. Illinois' independent-review law is a general health-care regulation, an area which historically has been a matter of local concern. *Travelers*, 514 U.S. at 661. The act neither "refer[s] to" nor "has a connection with" employee benefit plans, *id.*; rather, it regulates disputes between HMOs and

patients concerning the treatment decisions of physicians at HMOs. The law may indirectly burden ERISA plans, because some plans provide benefits through HMOs, and HMOs must now arbitrate disputes concerning physicians' treatment decisions. But *Travelers* teaches that this indirect effect is insufficient to require preemption under ERISA section 514(a), 29 U.S.C. § 1144(a). And *Pegram* provides support for this determination by holding that physicians' treatment and mixed eligibility/treatment decisions are not fiduciary decisions under ERISA. 530 U.S. at 231. The relates-to test has evolved, and its current manifestation acknowledges the states' strong interest in maintaining regulatory authority in traditional realms such as health care.

Even assuming, however, that section 4-10(a) "relate[s] to" ERISA plans, it is saved from preemption by subsection 514(b)(2)(A) of ERISA. That subsection saves state laws from preemption when those laws "regulate[] insurance." 29 U.S.C. § 1144(b)(2)(A).[4] The questions for decision are (i) whether the Illinois law is saved from preemption by ERISA subsection 514(b)(2)(A) as a "law of any State which regulates insurance"; and (ii) whether, even assuming that section 4-10(a) is a law regulating insurance, the law is nonetheless preempted because it creates a state law remedy that conflicts with ERISA's civil enforcement scheme. *Pilot Life*, 481 U.S. at 55.

Amici first show that section 4-10(a) regulates insurance. We then demonstrate that petitioner's argument that section

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[4] Another clause in section 514 creates an exception to the savings clause exception known as the deemer clause, section 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). This clause "makes clear that a state law that 'purport[s] to regulate insurance' cannot deem an employee benefit plan to be an insurance company." *Pilot Life*, 481 U.S. at 45. The deemer clause simply exempts self-funded ERISA plans from state laws that regulate insurance under the saving clause. Because the plan at issue is insured, not self-funded, the deemer clause does not apply. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990).

4-10(a) is preempted rests on a substantial overreading of *Pilot Life*, a decision finding ERISA preemption of a state common law cause of action that (i) was not preserved by the insurance savings clause and (ii) authorized punitive damages not permitted under ERISA's enforcement scheme. In contrast, there is no conflict with ERISA when a plan participant or beneficiary uses the Illinois independent-review law as a rule of decision in an enforcement action brought under section 502(a) of ERISA and seeking only relief authorized under ERISA's civil enforcement scheme.

A. Section 4-10(a) Is Directed At The Business Of Insurance.

This Court's "precedent provides a framework for resolving whether a state law 'regulates insurance' within the meaning of the saving clause." *UNUM Life*, 526 U.S. at 367. First, a court inquires whether "from a 'common sense view of the matter,' the contested prescription regulates insurance." *Id.* (quoting *Metropolitan Life*, 471 U.S. at 740). Then, the court considers the three McCarran-Ferguson Act factors as "guideposts, not separate essential elements" in assessing whether the regulation fits within the "business of insurance." *Id.* at 374.

Illinois' independent-review law is "directed toward" the business of insurance and thus "'regulates insurance'" in a common-sense understanding of the term. *Pilot Life*, 481 U.S. at 50. First, HMOs "are insurance vehicles under Illinois law." *Anderson* v. *Humana, Inc.*, 24 F.3d 889, 892 (7th Cir. 1994). The Seventh Circuit has so concluded in this case and others. This Court does "not normally disturb an appeals court's judgment on an issue so heavily dependent on analysis of state law." *UNUM Life*, 526 U.S. at 368 (citing *Runyon* v. *McCrary*, 427 U.S. 160, 181-82 (1976)). Petitioner and its *amici* have given the Court no reason to depart from its usual practice of deference to the appeals court's determination of state law.

Second, and equally to the point, HMOs evolved precisely in order that health-care providers would also bear risk and thus have an incentive to control costs. See *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 227 n.34 (1979) ("certain aspects" of advance payment medical benefits plans may be the "business of insurance"); *Washington Physicians Serv. Ass'n* v. *Gregoire*, 147 F.3d 1039, 1045-46 (9th Cir. 1998), *cert. denied*, 525 U.S. 1141 (1999). Illinois, like other states, enacted its independent-review law in direct response to the merger of the roles of health-care provider and insurer in HMOs and the resulting danger that medical-treatment decisions will be unduly infected by cost considerations. Other courts of appeals, like the Seventh Circuit, have generally concluded that HMOs are insurers. See *Express Scripts, Inc.* v. *Wenzel*, 262 F.3d 829, 835 (8th Cir. 2001) ("HMOs both spread and underwrite risk, and we agree with other circuit courts which have concluded that HMOs are insurers") (citing *Kentucky Ass'n of Health Plans, Inc.* v. *Nichols*, 227 F.3d 352, 364-65 (6th Cir. 2000), *Corporate Health Ins., Inc.*, 215 F.3d at 538, *Gregoire*, 147 F.3d at 1045-46). But see *O'Reilly* v. *Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990). Independent-review laws simply assure that HMOs bear the risk they have assumed, confirming that these laws regulate insurance for ERISA purposes.

Petitioner and its *amici* base their contention that section 4-10(a) is not directed at the insurance business and thus does not regulate insurance in the common-sense understanding of the term on the premise that the law may apply to some HMOs that are not acting as insurers. By definition, under the Illinois law, HMOs are entities that "provide or arrange" for health care in a way which spreads risk to the HMO or the providers that have contracted with the HMO. See 215 Ill. Comp. Stat. § 125/1-2(9). As we now show, the application of section 4-10(a) is limited to situations in which HMOs are acting as insurers.

Many HMOs provide or arrange health care and bear some or all of the resulting risk and thus combine the health-care provision and insurer functions. See Jonathan P. Weiner & Gregory de Lissovoy, *Razing A Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y & L. 75, 85, 87, 96 (1993). A law directed at HMOs which have both characteristics plainly is directed at the insurance business. Petitioner does not appear to dispute that section 4-10(a) regulates the business of insurance to the extent it is directed at HMOs that both provide health care and bear risk. Even under petitioner's theory, then, an independent-review law that so defined HMOs would not be preempted.

Some HMOs may provide or arrange health care by entering into agreements with medical providers which themselves bear *all* of the risk of medical costs higher than the insured's payments. This situation is not the norm. See *id.* at 96 (defining HMO as "a prepaid organized delivery system where the organization *and* the primary care physicians assume some financial risk for the care provided to its enrolled members"); *id.* at 86-87 ("risk may or may not be shared significantly by an intermediary, except, as noted, in the case of the two classes of HMOs, where the plan always bears the majority of risk"). But, leaving this practical point aside, petitioner and its *amici* argue that an HMO that provides or arranges care, but bears no risk, would meet the definition of an HMO under Illinois law but is not an insurer. Thus, the argument goes, section 4-10(a) is not directed at the business of insurance. This is wrong, as consideration of the actual application of section 4-10(a) illustrates.

An HMO cannot forbid a physician to provide or an insured to receive a medical treatment; it can only refuse to pay. Thus, it is when a primary care physician concludes that a particular medical treatment is authorized and the HMO refuses to *pay for* the treatment that the insured patient may seek independent review of the HMO's decision under section

4-10(a). If the physician and other health-care providers have themselves taken on all of the risk of the cost of health care, the physician's decision to provide a particular treatment does not impose a cost on the HMO, and it cannot constructively veto the treatment ordered by the physician by withholding payment.

As a practical matter, what this means is that the independent review law applies when an HMO has refused to pay, *i.e.*, when the HMO is acting as an *insurer*. See E.H. Morreim, *Confusion in the Courts: Managed Care Financial Structures and Their Impact on Medical Care*, 35 Tort & Ins. L.J. 699, 707 (2000) ("[i]n a mature capitation arrangement [*i.e.*, where providers bear all risk], the HMO has no need to dictate clinical decisions about which patients should receive what care because those decisions no longer pose a financial risk").[5] As a legal matter, what this means is that section 4-10(a) is "specifically directed toward" the business of insurance. *Pilot Life*, 481 U.S. at 50. Accordingly, even if there is a theoretical possibility or a *de minimis* number of instances in which section 4-10(a) might apply to HMOs not

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[5] Indeed, it is difficult to see how an HMO which has transferred all risk to health-care providers could prevent a patient from receiving medical treatment and thus end up in an independent-review proceeding. Assume that the HMO engages in utilization review and concludes that a treatment is not medically necessary. That decision is not binding on the physician or physician group, and the physician or physician group to whom the HMO has transferred financial risk may simply provide the treatment. *See* Morreim, *supra* at 709 & n.44 (quoting 99 Op. Ohio Att'y Gen. 44 (1999) ("[a] physician or other provider retains authority to provide whatever services are deemed appropriate for the patient, even if the services are not included under the plan of the health insuring corporation")). Utilization review "is merely deciding whether or not third-party payment is available," *id.* at 709 n.44 (quoting 60 Op. N.C. Att'y Gen. 100 (1992)). If the health-care provider has assumed all financial risk, the HMO cannot prevent treatment by withholding payment, and independent review of the physician's decision would have no consequence.

directly acting as insurers, the law regulates insurance in any common-sense understanding of the term.

Equally critically, an HMO that provides or arranges health care through a network of physicians which bears *all* risk acts as an insurer for additional reasons. First, the HMO is a reinsurer in this context. As explained in an article cited by petitioner, an HMO which provides or arranges for care "is legally committed to provide care" for its enrolled members. Weiner & de Lissovoy, *supra* at 96; *id.* at 85 ("[i]n many managed care plans, the intermediary is legally committed to provide care, or to arrange for its provision, via a network of providers with which it has prenegotiated contracts"). The insured has a contract for medical care *with the HMO* at a specified monthly or annual fee, and it is the HMO that is ultimately responsible – *viz.*, the insurer – with respect to the provision of covered care.

Second, the HMO that arranges care from providers bearing all risk is processing claims for patients to whom it is contractually obligated to provide care. Claims processing is an archetypal insurer function. See Keeton & Widiss, *Insurance Law* § 6.9(a) (1988) ("Regulation of Claims Process"); *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 136 & n.2 (1982) (Rehnquist, C.J., dissenting) (explaining that the "process of claims adjustment – the determination of the actual payments to be made to the insured for losses covered by the insurance contract" – is central to the contract between the insurer and the insured and thus the "essence of the 'business of insurance'"). The HMO which simply provides or arranges care by contracting with insurers is the agent of those insurers. An HMO may not avoid legal characterization as an insurer by itself performing only one insurance function and contracting out the rest.[6]

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[6] Petitioner and its *amici* suggest that some HMOs do not contract with employers, employer groups, or patients to provide insurance and simply administer claims for health-care providers. Such HMOs may fall outside of the Illinois act's definition of HMOs for they do not "provide or arrange for . . . [a] health care plan[]." 215 Ill. Comp. Stat. § 125/1-2(9). In that circumstance, too, however, the HMO is a claims processor and agent for the insurer health-care providers. If such HMOs are covered, they are acting as and on behalf of insurers and performing a core insurer function.

Finally, Illinois' regulation of HMOs "is grounded in policy concerns specific to the insurance industry," when its business merges with the business of health care. *UNUM Life*, 526 U.S. at 372. Specifically, Illinois, like many states and *amici*, is concerned about the ability of health-care providers, especially physicians, to make judgments about necessary medical treatment without undue emphasis on cost considerations when the insurance and health-care provider functions are combined. Section 4-10(a) is directed at this specific problem. Indeed, insofar as any policy concern not specific to the insurance industry is implicated by section 4-10(a), it is the State's legitimate and appropriate policy concern with health-care regulation. Common sense dictates that the Illinois law falls within the insurance savings clause and thus is saved from ERISA preemption. Cf. *Corporate Health Ins.*, 215 F.3d at 538 ("the independent review provisions are aimed at insuring entities and regulate the insured-insurer relationship, [so] they meet the common sense test of the saving clause").

The McCarran-Ferguson factors, which this Court describes as "guideposts" or "considerations to be weighed" in determining whether a law regulates insurance, also strongly support application of the insurance savings clause here. *UNUM Life*, 526 U.S. at 373-74. Those factors are whether the law "has the effect of transferring or spreading a policyholder's risk," *Metropolitan Life*, 471 U.S. at 743; whether it serves as "an integral part of the policy relationship between the insurer and the insured," *id.* at 743; and "whether the rule is limited to entities within the insurance industry," *UNUM Life*, 526 U.S. at 375.

As both the Seventh and Fifth Circuits have concluded, independent-review laws like section 4-10(a) easily satisfy the second and third McCarran-Ferguson factors. Such laws are integral to the policy relationship, because they "change the bargain between insurer and insured." *Id.* at 374. See also *id.* at 375 (the law "dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship") (internal quotations and citation omitted). Moreover, for reasons set forth above, they also directly regulate the insurance industry. See *id.* (the law "focuses on the insurance industry"); *id.* (the rule "'does not merely have an impact on the insurance industry; it is aimed at it'") (quoting *FMC Corp.*, 498 U.S. at 61)). Because the common-sense view of the law is "verif[ied]" by two of the remaining three McCarran-Ferguson factors, an analysis of the first factor "need not [be] pursue[d]." *Id.* at 374. If this Court were to address whether section 4-10(a) spreads risk, *amici* submit that the law transfers a policy holder's risk. Specifically, it shifts the risk of erroneous medical-necessity determinations from the insured patient to the HMO, potentially raising premiums and spreading risk among all insurance policy holders. See *Metropolitan Life*, 471 U.S. at 742 (holding that a state law adding a benefit to an insurance contract required the parties to spread an additional risk to all policyholders).

The insurance savings clause applies here. That leaves for decision the question whether section 4-10(a) is "nonetheless preempted because it conflicts with substantive provisions of ERISA." *Pilot Life*, 481 U.S. at 357. To that question we now turn.

B. Moran's Action Does Not Conflict With ERISA Section 502(a).

Section 4-10(a) does not conflict with any provision of ERISA and specifically does not conflict with its civil enforcement scheme. Although respondent Moran initially filed a state law action to enforce section 4-10(a), her lawsuit

was removed to federal court. The district court determined that her state law action was a suit "to recover benefits due . . . under the terms of [a] plan," 29 U.S.C. § 1132(a)(1)(B), and thus preempted. The Seventh Circuit affirmed this decision, and respondent did not cross-petition. Accordingly, the case before this Court is a suit to recover benefits brought under section 502(a)(1)(B) of ERISA's civil enforcement scheme. Put differently, this action does not conflict with ERISA's exclusive civil enforcement scheme; it utilizes it.[7]

The most apposite precedent of this Court is *UNUM Life*. There the insurer argued that a state rule conflicted with ERISA's enforcement scheme. This Court, however, simply pointed out that the insured had "sued under § 502(a)(1)(B) 'to recover benefits due . . . under the terms of his plan.' The [state law] rule supplied the relevant rule of decision for this §502(a) suit." 526 U.S. at 377. Similarly here, section 4-10(a) simply supplied the relevant "rule of decision" for the insured's section 502(a) suit – *viz.*, it determined through an independent-review process akin to arbitration whether the insured's primary physician correctly determined that she should have microneurolysis surgery.[8] See also *Metropolitan*

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[7] For that reason, in this case, as in *UNUM Life*, the Court need not decide whether a state insurance law that creates an alternative state-law remedy comes within the savings clause and is saved from preemption or whether it nonetheless conflicts with ERISA's exclusive enforcement scheme and is preempted under *Pilot Life*. Here the claim before the Court is an ERISA section 502(a) claim, and the state law merely provides the "relevant rule of decision in [that] §502(a) action." 526 U.S. at 376-77 & n.6.

[8] The Illinois act mandates external review not internal review. Neither ERISA nor its implementing regulations purport to limit external review of medical-necessity determinations. In contrast, ERISA does address internal review procedures; even there, however, ERISA defines only a floor that such processes must achieve rather than occupying the field. *See* 29 U.S.C. § 1133 (requiring plans to provide notice and the opportunity for review of denied claims); 29 C.F.R. pt. 2560 (setting forth

Life, 471 U.S. at 744 (holding that a state law mandating the provision of certain insurance benefits was saved from preemption by the savings clause); *FMC Corp.*, 498 U.S. 60 (holding that a state anti-subrogation rule was saved from preemption although the law affected the plan's payment of benefits).

The state laws at issue here, in *Metropolitan Life*, and in *FMC Corp.* are all, as a matter of state insurance law, incorporated into the terms of the insurance purchased by plans in the pertinent states. Each is simply part of the terms and conditions an insurer accepts as part of the cost of doing business in the state in question,[9] and none thereby conflicts with any substantive provision of ERISA, including its civil enforcement scheme.[10] Quite to the contrary, Moran's insurance policy provided that Rush Prudential would pay for her medically-necessary health care. ERISA section 502(a) specifies that Moran, as a plan beneficiary, is entitled to such

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the minimum requirements for benefit claims procedures for employee benefit plans). *See also UNUM Life*, 526 U.S. at 377 (holding that "[b]y allowing a longer period to file than the *minimum* filing terms mandated by federal law, the [state law] rule complements rather than contradicts ERISA and the regulations").

[9] That incorporation is not simply implicit here. This plan, as the Court of Appeals expressly noted, expressly incorporates state law conditions.

[10] The Department of Labor's claim processing regulations specifically express the Department's belief that the regulations do not preempt state insurance laws authorizing independent review. The regulations specify that they preempt state laws regulating insurance only "to the extent that such law prevents the application of a requirement" of the claims processing regulations and further that for this purpose, "a State law regulating insurance shall not be considered to prevent the application" of the claims processing regulations "merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of the foregoing." 29 C.F.R. 2560.503-1(k)(1) & (2)(i).

payment. Thus, section 4-10(a) furthers, rather than frustrates, congressional intent.

Pilot Life is not to the contrary. In that case, this Court considered whether Mississippi common law creating a state cause of action for bad-faith breach of contract conflicted with ERISA's civil enforcement scheme. The Court held that the state law cause of action "relate[d] to" an ERISA plan and rejected the argument that the insurance savings clause applied. That analysis would have decided the case; but, in reaching the conclusion that the state cause of action was preempted, this Court went on to characterize ERISA's civil enforcement provisions as the exclusive remedy for benefits under an ERISA plan. 481 U.S. at 52-56.

In its discussion of ERISA's civil enforcement scheme, the Court explained that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.* at 54. And, in fact, this Court has found ERISA conflict preemption only where state law provides remedies not authorized by ERISA. See, *e.g.*, *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. at 58, 62-63 (1987) (state law claim seeking extracontractual damages); *Pilot Life*, 481 U.S. at 55 (same); *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 145 (1990) (same). No such concerns are implicated here. The remedy Moran sought was the payment that Rush Prudential had promised her, the same remedy guaranteed by ERISA section 502(a). By contrast, an award of punitive damages, as the plaintiffs sought in *Pilot Life*, is a substantively different remedy, at odds with ERISA's civil enforcement scheme. Respondent's claim arises under ERISA section 502(a), and she is not asserting that section 4-10(a) entitles her to legal or equitable remedies beyond those provided under ERISA.

The Illinois act mandates that medical-necessity disputes between the HMO (an insurer) and the primary care physician

of a patient (the insured) be subject to independent external review or arbitration. Respondent seeks enforcement of this determination through an ERISA action for benefits. This is a far cry from the assertion of either an alternative state-law *judicial* claim for benefits or additional substantive remedies (*e.g.*, punitive damages) under an ERISA plan, such as those at issue in *Pilot Life*. Respondent's action is not in conflict with ERISA's enforcement scheme.

Indeed, it is often acknowledged that ERISA's exclusive remedial scheme was modeled on that in section 301 of the Labor Management Relations Act, 29 U.S.C. § 185(a), and was intended to federalize ERISA remedies in the same way that section 301(a) has federalized remedies for violations of collective bargaining agreements. See, *e.g.*, *Pilot Life*, 481 U.S. at 54-56. Section 301(a) does provide an exclusive remedy for violations of collective bargaining agreements, but it does not prohibit the voluntary arbitration of such claimed violations subject to judicial enforcement under section 301(a).[11] In fact, employers and labor organizations routinely file section 301 actions to enforce or vacate arbitration awards in which federal courts defer virtually completely to the factual findings and legal conclusions of neutral labor arbitrators. See *Major League Baseball Players Ass'n* v. *Garvey*, 121 S. Ct. 1724 (2001).

By analogy here, section 502(a) of ERISA provides the exclusive cause of action for rights guaranteed under ERISA. But this exclusivity does not bar the arbitration of disputes between an HMO (the insurer) and the primary physician of a patient insured by the HMO (the insured) to determine the

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[11] *Cf. Lingle* v. *Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 413 n.12 (1988) ("as a general proposition, a state-law claim may depend for its resolution upon both the interpretation of a collective-bargaining agreement and a separate state-law analysis that does not turn on the agreement. In such a case, federal law would govern the interpretation of the agreement, but the separate state-law analysis would not be thereby preempted").

medical necessity of certain treatments, where that arbitration is mandated by a state insurance law. Those determinations may then be *enforced* through ERISA's exclusive enforcement provision. The Illinois law no more infringes upon ERISA's exclusive enforcement scheme than labor arbitration infringes upon section 301(a).

"If a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." *FMC Corp.*, 498 U.S. at 64. Such regulation then becomes part of the body of rules governing adjudication of ERISA enforcement actions and, in that context, plainly is not preempted. The alternative is not federal regulation, but *no regulation* of HMOs as insurers and health-care providers making medical-necessity determinations. As we now show, that situation would be insupportable, for such regulation is critical to patients and physicians in the managed-care context.

III. INDEPENDENT REVIEW OF HMO MEDICAL NECESSITY DECISIONS IS CONSISTENT WITH ERISA'S PRESERVATION OF THE TRADITIONAL STATE ROLE IN REGULATING INSURANCE AND HEALTH CARE AND FURTHERS ERISA'S PURPOSE OF PROTECTING PLAN PARTICIPANTS AND BENEFICIARIES THROUGH COMPLEMENTARY STATE AND FEDERAL REGULATION.

"Throughout our history the several States have exercised their police powers to protect the health and safety of their citizens." *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 475 (1996). This case involves a state's use of its police powers to regulate the business of insurance in order to protect the health of its citizens. Because health issues are "primarily, and historically, . . . matter[s] of local concern," *Hillsborough County*, 471 U.S. at 719, this Court "presum[es] that state or local regulation of matters related to health and safety is not invalidated under the Supremacy Clause." *Id.* at 715.

ERISA's explicit savings of state insurance law and the presumption against preemption of a state's exercise of police power in the area of health provides the context for this case.

Responding to the exponential growth of managed care and the perceived subversion of medical judgment resulting from the commingling of the health-care and insurance functions, many states passed independent-review laws. As set forth above, far from manifesting a clear intention to preempt independent- review laws, Congress explicitly saved such laws from preemption through the insurance savings clause of ERISA, 29 U.S.C. § 1144(b)(2)(A). That congressional decision has permitted the development of laws that address the serious problems resulting from the emergence of managed care. And, the states have quite appropriately and expeditiously addressed these problems. As we now show, independent-review laws protect critical interests of insured patients and physicians in areas traditionally regulated by the states.

A. Independent-Review Laws Fill A Critical Need In Insurance Regulation.

As the AMA has informed Congress, "[t]he absence of independent review enables plans to make unfair and arbitrary decisions with virtually no consequences." *Employer Health Plan Accountability: Do Plan Participants Have Adequate Protections?: Hearing Before the House Subcomm. on Employer-Employee Relations, House Comm. on Educ. and the Workforce*, 106th Cong. 127 (1999) (statement of Timothy T. Flaherty, M.D., American Medical Association) ("*Flaherty Statement*"). The overall goal of independent-review laws, accordingly, is to ensure that persons enrolled in managed-care programs receive medically-necessary health care. Geraldine Dallek & Karen Pollitz, *External Review of Health Plan Decisions: An Update* 1 (Kaiser Family Foundation May 2000) ("*External Review Update*"). Such laws work toward that goal in a number of different ways.

Initially, independent-review laws help achieve the objective of having medical-necessity decisions made by physicians, not by insurance company administrators. "[M]edical necessity decisions are ultimately medical decisions and should continue to be treated as such. [They] must always be made in accordance with those generally accepted standards of medical practice that a prudent physician would follow when treating a patient." *Flaherty Statement* at 130. Independent external review helps ensure "that doctors will be reviewing doctor decisions," generally through a "faster" process. 147 Cong. Rec. H5204 (daily ed, Aug. 2, 2001) (statement of Rep. Johnson). As the AMA has testified, "a definition of medical necessity that is determined *by physicians* is one of the most critical factors in the review process." Susan Hershberg Adelman, M.D., AMA, *Statement to the Department of Labor Re: Proposed Claims Procedure Regulations* 3 (Feb. 17, 1999) (emphases in original omitted). Accordingly, the AMA has advocated, and many of the state laws provide, that independent review "be based on the medical judgment of a physician in the same specialty, actively practicing medicine in the same jurisdiction as the practitioner who is proposing or providing the reviewed service." *Id.* at 9 (emphases in original omitted).

In this regard, from the perspective of *amici*, a key benefit of independent review is that it protects and improves the relationship between patients and physicians. This is accomplished in major part by maintaining the primacy of physicians in the determination of what care a given patient should receive. As Senator Kennedy has explained, one major concern with managed care is that doctors and nurses no longer make critical medical decisions regarding treatment; instead, "accountants [who] do not have the training, do not know the patient, and do not know the complete medical circumstances surround[] the patient's case" are making those quintessentially medical decisions. 147 Cong. Rec. S6410 (daily ed. June 19, 2001) (statement of

Sen. Kennedy). Cf. 147 Cong. Rec. H5201 (daily ed. Aug. 2, 2001) (statement of Rep. Cooksey) (arguing that external review and other patient protections "go a long ways towards reestablishing the patient-physician relationship").

Independent-review laws also give physicians a forum in which to battle for the medical interests of their patients. The patient-physician relationship remains at the core of our health-care delivery system, and a patient's trust and belief in the integrity of the medical judgments made by his or her physician is critical. Independent-review laws allow physicians to protect and preserve the integrity of the patient-physician relationship in the managed-care context.

For similar reasons, independent-review laws will almost surely improve public perceptions of the health-care system. The growth of managed care has been accompanied by a corresponding growth in patient frustration, disappointment, and anger concerning their medical care. See Marc A. Rodwin, *Backlash as Prelude to Managing Managed Care*, 24 J. Health Pol., Pol'y & L. 1115, 1117-18 (Oct. 1999). Not surprisingly, "[e]xternal review of health plan decisions is seen by many as a significant component of state and federal patient protection proposals because it responds directly to consumer concerns about inappropriate denials of service." Helen Schauffler & Juliette Cubanski, *External Review of Health Plan Decisions Policy Brief, in California Health Policy Roundtable* 2 (Kaiser Family Foundation Jan. 1999) ("*Schauffler & Cubanski Policy Brief*"). "The use of independent review also helps to standardize a process that many consumers believe is subject to random denials of needed care." *External Review Update* at 18. In fact, "[h]ealth plan industry representatives stress[] [that] external review helps improve public perceptions about managed care." Karen Pollitz et al., *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* vi (Kaiser Family Foundation Nov. 1998) ("*External Review Overview*"); see also Tracy E.

Miller, *Center Stage on the Potential Protection Agenda: Grievance and Appeal Rights*, 26 J. L. Med. & Ethics 89, 95 (1998) ("Grievance and appeal procedures, especially those that include external review, may also bolster consumer confidence in the health plan. In addition, appeal procedures may prevent undertreatment. . . . .").

An additional benefit of independent-review laws is that they reduce the need for litigation. An August 2001 study examining the patient protection laws enacted in eight states noted that "[i]ndependent review processes operate in all eight states and were generally considered effective mechanisms for addressing most disputes over [managed care organization] coverage before injuries occur, limiting the need for litigation." Patricia Butler, *Key Characteristics of State Managed Care Organization Liability Laws: Current Status and Experience* 5 (Kaiser Family Foundation Aug. 2001). "External review is widely cited as a fair, impartial, and usually expeditious and cost effective way to resolve disputes." *External Review Update* at 1.

The experience of the State of Texas demonstrates that patients will utilize independent review in preference to the expensive and protracted process of litigation. 147 Cong. Rec., H4417-18 (daily ed. July 31, 2001) (statement of Rep. Pallone) ("What we are seeing is now that patients know that they can go outside the HMO and have an independent review of a denial of care. They are exercising that. They are not going to court because nobody wants to go to court and have litigation and spend money and go on and on for years. Nobody wants to do that, not the patients any more than the HMOs or the insurance companies."); see also 147 Cong. Rec. H3503 (daily ed. June 25, 2001) (statement of Rep. Green) (noting that Texas has had only 17 cases taken to

court in the four years since enactment of its external review law).[12]

Finally, many states use external review to conduct oversight of insurers, including "identify[ing] and correct[ing] a troubling pattern of decision-making regarding denials" of services and improving the overall quality of health care. See *External Review Update* at 18. The evidence is that "[e]xternal review appears to have a sentinel effect on health plan behavior." *External Review Overview* at 6 (emphasis omitted); *id.* at 50 ("external review enhances general oversight of health plans").[13]

B. State Regulation Of HMOs As Insurers Is Appropriate And Beneficial.

It is critically important that states continue to be able to mandate independent review of medical necessity decisions. As noted above, states have traditionally regulated both insurance and health care to protect the interests of its citizens. See *supra* at 8-9. "Part of traditional state authority to set standards for the insurance industry, state requirements for HMO grievance procedures have existed for many

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[12] *See also* Roderick B. Mathews, *The Role of ADR in Managed Health Care Disputes*, 54 Disp. Resol. J. 8, 11 (1999) ("The advantages of [alternative dispute resolution] are particularly compelling in the managed health care context. In addition to speed and efficiency, low cost, privacy/confidentiality, and non-precedential resolution, other positive considerations include: avoiding the win/lose confrontation of the courtroom and maintaining the possibility of continued business or personal relationships; ready accessibility; and enhanced perception of fairness through the use of independent neutrals.").

[13] Notably, experience in the States that have enacted independent review laws indicates that "the indirect as well as direct costs of external review" are "modest." *External Review Overview* at 52. In fact, in Texas, which has a particularly strong patients' protection law, "the costs of HMO premiums . . . have risen but *less* than the national average." 147 Cong. Rec. H4417 (daily ed. July 31, 2001) (emphasis supplied) (statement of Rep. Pallone).

years . . . ." Miller, *supra* at 91. Preempting state independent-review laws would both displace traditional state authority and leave insured patients unprotected.

States have the experience, flexibility, and familiarity with local conditions to determine the need for an independent-review law in their respective jurisdictions and to enact a law tailored to local requirements. At present, the displacement of state regulation would leave HMOs' medical-necessity determinations virtually unregulated. The enactment of patient protection legislation in the states underlines the importance of leaving states free to legislate in the areas of insurance and health care.

If Congress ultimately does act in this field, its action will have been informed by experience with "the merits of evolving state laws" addressing independent review. *Id.* at 95. See also 147 Cong. Rec. H5199 (daily ed. Aug. 2, 2001) (statement of Rep. Norwood) (acknowledging that patient protection bills have been languishing for six years in Congress). States have acted as laboratories for the regulation of HMOs acting as insurers by employing different forms of independent review. As state independent-review laws are adopted and analyzed, other states (and potentially Congress) could choose to model their laws after those that came before them. See *Schauffler & Cubanski Policy Brief* at 5 ("External review programs in many other states can serve as models for California in establishing an effective external review system."); Michael E. Ginsberg, *HMO Grievance Processes*, 37 Harv. J. on Legis. 237, 246-47 (2000) (using other states' experience to assess likely costs and benefits from new Maryland external review law). Recognizing the merits of the various states' independent review laws, Senator Edwards pleaded with his colleagues *not* to preempt state law because "State law has traditionally controlled these kinds of cases" and argued in favor of legislation "deferring almost entirely to the oversight of medical judgment that has traditionally been regulated by State law." 147 Cong. Rec.

S1368-69 (daily ed. Feb. 14, 2001) (statement of Sen. Edwards).

As this analysis makes clear, independent review laws lie at the heart of the traditional state regulation of insurance and health care and have many benefits for patients, physicians, and society as a whole. The strong presumption against preemption of traditional state police powers in combination with ERISA's insurance savings clause has allowed state regulation of managed care to emerge, including independent-review laws with their numerous attendant benefits. Section 4-10(a) is saved from preemption by the insurance savings clause of ERISA and does not conflict with ERISA's civil enforcement scheme. Illinois' power to regulate conduct at the confluence of the businesses of insurance and health care should be affirmed.

CONCLUSION

For the foregoing reasons, as well as those set forth in the respondent's brief, the decision below should be affirmed.

Respectfully submitted,

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